IN THE COURT OF COMMON PLEAS

SUMMIT COUNTY, OHIO

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KAREN L. ARMOUR, etc., et al., : Judge Cosgrove

Plaintiffs, : Case No. 2002-07-4063

v. :

PATRICK RICH, D.O., et al., :

Defendants. :

- - - - - - - - - - - - - - - - - X

Washington, D.C.

Monday, January 12, 2004

Videoconference Deposition of DR. BRUCE AMMERMAN, a witness herein, called for examination by counsel for Plaintiff in the above-entitled matter, pursuant to notice, the witness being duly sworn by SUSAN L. CIMINELLI, a Notary Public in and for the District of Columbia, taken at the offices of Kinko's Copy Center, 2020 K Street, N.W., Washington, D.C., at 12:55 p.m., Monday, January 12, 2004, and the proceedings being taken down by Stenotype by SUSAN L. CIMINELLI, CRR, RPR, and transcribed under her direction.

APPEARANCES:

On behalf of the Plaintiffs:
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EXHIBITS

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Whereupon,
DR. BRUCE AMMERMAN,
business address at 3301 New Mexico Avenue, N.W., Washington, D.C., was called as a witness by counsel for Plaintiff, and having been duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY COUNSEL FOR PLAINTIFFS
BY MR. MISHKIND:

Q. Would you please state your name for the record.

A. Bruce Gorge, G-O-R-G-E, Ammerman.

Q. Dr. Ammerman, my name is Howard Mishkind and I'm going to be asking you some questions today concerning the opinions that you have expressed in your report of August 11th and the opinions that you anticipate providing at the time of the trial of this case, which is set for the early part of March.

Before I get into my questions, let me just indicate on the record that it's five minutes of one and that Mr. Murphy, who represents one of the co-defendants, has not shown up at this point. He was noticed. We are going to start with some of the preliminaries, Doctor, and then perhaps take a break, 10, 15 minutes into the deposition and if he has not

shown up at that point, we'll make a call to his office to see whether somehow he is otherwise indisposed or planning on coming, okay?

A. Okay.

Q. Doctor, I have your report dated August 11, 2003 in front of me and it has your address on New Mexico Avenue in Washington, D.C., is that your, is that your only business address?

A. Yes.

Q. You don't have any other offices other than that office?

A. No, sir.

Q. I don't have your CV, although we are, Mr. Kuri is searching for a copy of it, but given that I don't have a CV right now, I'm going to ask some questions that might otherwise have been answered by a copy of that, but you are a neurosurgeon, as I understand it, correct?

A. Yes, sir.

Q. If I had a CV in front of me, would it set forth your publications that you have been involved in?

A. Yes.

Q. Is your CV thick? Can you tell me how many articles or book chapters or books you have

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written?
A. I think there are eight or nine publications.
Q. Any book chapters or are they all journal articles?
A. No. There is a book chapter on a microneurosurgical text many years ago. The others are going to be articles.
Q. Are they all peer reviewed articles, Doctor?
A. I believe so.
Q. Do any of those articles touch on the topic of causation in terms of causation of stroke in a patient?
A. At least one deals with treatment of aneurism, which is quasi-related but not, I have written nothing that deals specifically with the issues at hand as I envision them here.
Q. Beside the article on aneurism, the other articles would be very simply put unrelated to the medical subject matter in this case?
A. I think so. I don't have it in front of me, but I think that's correct.
Q. You probably know it by memory better than I do, though.

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A. A bit.
Q. All right. Have you reviewed any literature at all in preparing yourself either to write your letter of August 11th or in connection with the opinions that you hold in this case?
A. No, sir.
Q. Are there any journal articles, books, book chapters that you believe to be relevant to the issue of causation that would support any of the opinions that you hold or authors that you could cite me to that you believe have written on the topic that would support the opinions that you hold in this case?
A. No, sir.
Q. Tell me briefly if you would about your practice. All I know is that you are a neurosurgeon but I'd like to know what your day-to-day practice consists of, please?
A. I'll be glad to. I practice basically adult neurosurgery. I see occasional kids but I really don't operate on little kids. I spend my time either at the office as I did this morning before driving downtown here, or at Sibley Hospital, which is a community hospital here in Washington, D.C., where I made rounds this morning, where I'm going to

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operate when we are done with this today.
I also spend time at George Washington University Hospital, where I'll be tomorrow, and where I also operate and teach, and it's those three places I spend just about almost all my time.
Q. What percentage of your practice, if you can tell me, involves the management of stroke patients?
A. Currently I suspect it's certainly less than 10 percent, and as far as the actual management, less than 10 percent.
Q. Do you see patients in follow up for non-neurosurgical issues?
A. Well, I look upon neurology as part of neurosurgery and I treat patients who certainly have no surgical issues or indications. In fact, many. So I evaluate and treat patients both as a neurosurgeon and someone who may need neurosurgical services but also patients who have neurologic problems, vascular disease, seizures, other things, neuropathies, other things that don't require surgery.
Q. What percentage of your patient population, if you will, involve nonsurgical management, as opposed to surgical issues with follow

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up by you after the surgery?
A. I can only answer it this way. Most patients I see don't get operated on. I probably operate typically three or four times a week, but I probably end up seeing, gosh, probably 50 patients a week, counting new patients and old patients. Of course, that could be seen a number of times but the vast majority of patients I see don't require cervical intervention.
Q. How do you typically get your patients? Are they referred from a particular subspecialist?
A. It varies. I would say probably, and I don't know how, one versus the other, the most common would either be from internist/family practitioners and orthopedic surgeons. That would probably be the two most frequent. And then a variety of other professionals, be it neurologists, be it, just one second, we have rheumatologists, geriatricians, whatever. But internists, family practice physicians, and orthopedist would probably be at the head of the list.
Q. What would be a typical circumstance where a neurologist would refer a patient to you, as opposed to the neurologist continuing to treat and manage that patient?

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A. In a couple of contexts. Obviously if he or she feels the patient may require surgery or some type of surgical evaluation, that would be the most frequent and not infrequently for sort of a second opinion to get another opinion. Those are probably the two most common.
Q. Are you board certified in neurology?
A. No, sir. I'm board certified in neurological surgery of which one third of our oral board is neurology.
Q. The board that you were certified by is called what?
A. The American Board of Neurological Surgery.
Q. Are you board certified in any other subspecialties?
A. No, sir.
Q. There is a little bit of a delay, Doctor, on the, at least on the video. When you were talking before, at least the video that I saw you were drinking your Sprite. Are you having the same thing with us from our end?
A. Yes, sir. That's why I'm intentionally trying to delay. I'm not being impolite. There is a delay for each of us.

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MR. KURI: Your picture is actually extremely delayed, but your voice seems to be coming through. It's really strange right now.
MR. MISHKIND: You are like moving in slow motion, so I'll do my best as well to pause and I'm not intentionally doing that, just so that we don't overlap each other.
THE WITNESS: No problem. You guys are also in slow motion.
BY MR. MISHKIND:
Q. Sometimes figuratively, other times literally.
A. No comment. Go ahead.
Q. Okay. Do you hold yourself out as an expert in the area of pulmonary medicine?
A. No, sir.
Q. When is the last time, Doctor, that you diagnosed and treated a patient with a stroke that did not require surgical intervention?
A. Well, I'm sure within the last several weeks. Most patients I see who have strokes do not require surgical intervention.
Q. And what percentage of your patient population that you see are stroke patients?
A. Again, as I said, it would probably be

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less than 10 percent of the patients I see. Now, I see patients who have cerebral vascular disease who have not had strokes and sometimes it's a little hard to separate it out but seeing this problem has been an ongoing part of my practice and certainly for the first 10 or 15 years, I saw lots and lots and lots of stroke patients, more than we do now as we have gotten more neurologists on staff at the hospital.
Q. Can a pulmonary embolism precipitate or cause a patient to experience a cerebral vascular accident?
A. If a pulmonary, the answer is yes. If it leads to such a degree of hypotension, it will cause anoxia. The answer is yes.
Q. Before we talk about the details of Mrs. Speicher's case, I want to ask you first about your medical, legal experience and then get a sense of what it is that you have in front of you and then we'll try to dive right into the opinions that I believe you will be providing in this case, okay?
A. Okay. Do you have something banging behind you?
MR. KURI: Yes. It's the heater.
BY MR. MISHKIND:
Q. Yes. They got one of those old heaters

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that unless Mr. Kuri is trying to manipulate it now to see if it helps, but --
MR. KURI: I can't get into it.
THE WITNESS: Don't try.
BY MR. MISHKIND:
Q. You have given deposition testimony before, correct?
A. Yes, sir.
Q. Have you testified in federal court, as well as in state court?
A. Yes.
Q. We are now very early into 2004, so have you given any deposition or trial testimony in the calendar year 2004 prior to today?
A. I'm pretty sure I gave a deposition last week. And I know I did in December.
Q. The deposition last week, where was that case, the medical subject matter? Was it a case in Ohio or elsewhere?
A. Oh, it was, no. It was, gave the deposition in my office. I don't recall what it was about. I just recall that last week there was a deposition. I'd have to go back. I don't recall the details of it. Where was the case? You mean, where was the case filed?

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Q. You gave a deposition in the case in your office last week, but the malpractice or the alleged malpractice occurred in what state?
A. I don't even recall if it was a malpractice case. You just asked me about depositions. I give infrequent malpractice case depositions. If that's what you are asking me, I know I gave one in December. I don't recall what the one was last week. I'm not sure that that was.
Q. How many times have you been deposed in medical malpractice cases?
A. I would guesstimate probably two, three dozen, in that ballpark.
Q. The one a week ago, was that a medical malpractice case?
A. I do not recall. I do not recall. I don't recall.
Q. Do you remember the name of the attorney that you were serving at the request of?
A. I do not. If I did, then I might remember the case. I can't tell you.
Q. You don't remember the medical subject matter of the case from last week either?
A. If I did, I'd be pleased to share it with you.

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Q. In December, was that a medical malpractice case that you testified in?
A. Yes. That one I do recall.
Q. What were you testifying on behalf, the defense or on behalf of the plaintiff in that case?
A. In the December case was the plaintiff.
Q. Who was the plaintiff's attorney?
A. It was a lady in Virginia. Her last name was I believe Cofield, Judy Cofield.
Q. I'm sorry. Her first name was?
A. I believe it was Judith or Judy.
Q. And was that a trial or just deposition?
A. I gave a video deposition because the trial was coming up right after the holiday, and I wasn't available, so it was a video in my office.
Q. And you had been deposed in a discovery deposition in that case before your video was conducted?
A. I think so. I'm not positive.
Q. Do you remember what the medical subject matter in that case was?
A. That one I do. That was a patient who had had a revision of a cervical fusion, and had a plate put in and the plate was put in improperly. And she required additional surgery subsequently.

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Q. Of the two to three dozen medical malpractice matters that you indicated, those are ones that you have given deposition testimony in, is that correct?
A. Yes, sir. Over the years. Yes.
Q. Tell me of the two to three dozen medical malpractice cases, how many of those have been where you were serving as the plaintiff's expert and how many where you were serving as the defense expert?
A. My best guesstimate, it probably breaks down to be 20-80, 70-30 plaintiff's, defense.
Q. Has that been fairly consistent since you have been doing review in medical malpractice cases?
A. My sense is over the last few years, yes. Prior to that, my sense is the numbers would be higher for the defense than the plaintiff. In other words, greater. Greater than 80 percent defense, which is probably no longer the case.
Q. Now it's more like what two-thirds to 70 percent defense, with the balance being plaintiff?
A. Yes. And actual testimony is probably about, and I'm guessing, but my guess is it's about 70-30, 75-25. 10 years ago, the numbers might have been more towards the defense side than they are currently.

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Q. How many cases in the medical malpractice area do you review on a yearly basis?
A. My guesstimate is it's probably around a dozen cases a year, give or take I'm asked to look at.
Q. Tell me the percentage breakdown plaintiff versus defense on those cases that you reviewed per year?
A. It's probably pretty close to even, maybe a shade more towards the plaintiff's side that I'll be asked to look at.
Q. You indicated that you testified in federal court so you have been required, I presume, to prepare a Rule 26 disclosure in terms of deposition and trial testimony, correct?
A. You asked me something I can't answer. There is a list which is probably about a year or so old of depositions and trials which I have given up to that point. The answer is yes. I don't know what you are calling it, but if that's what it is, the answer is yes.
Q. And you say it's about a-year-old so it would have been through the year 2002?
A. It's into 2002. Yes, sir.
Q. Do you know whether you prepared any type

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of a list, partial or complete, for the year 2003?
A. I know I haven't done it. I'm the one that does it and it has not been done. I haven't done it.
Q. All right. Just so I'm clear, the last list whether it's partial or complete would relate to the year 2002, is that correct?
A. Yes.
Q. You have not sat down either on your own urging or at the urging of someone else and prepared a list of cases in 2003 that you testified in deposition or trial?
A. I haven't gotten around to it. The answer is I have not.
Q. How many years have you been doing medical legal work, whether it's medical malpractice or any other type of medical legal work?
A. If you are including things like Workmens' Comp evaluations, that sort of thing, probably greater than 20 years.
Q. Do you also perform examinations where a patient is being sent to you for purposes of a one-time exam which may be referred to as an independent medical exam or a defense medical exam?
A. With the exception of the word defense, I

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would say yes because I have an open door policy in my office that I do evaluate patients, probably three, four, five times a week out of the 50 or so I see that are patients I don't treat and probably the majority come from defense lawyers but I see them for plaintiffs' lawyers, I see them for Social Security. I see them for Workmen's Comp, things of this nature that I don't treat that are really runs the gamut throughout all of those.
Q. What percentage of your income would you say is generated from doing medical malpractice reviews, depositions, and testimony, as well as the other gamut where you are seeing patients that come to you that you are not treating that come to you either through Social Security from a defense lawyer or another lawyer?
A. I would guesstimate 10 percentish in that ballpark.
Q. Have you ever authored a report in a medical malpractice case other an the Speicher case where you were providing opinions as to the causation of a stroke in a patient?
A. I wouldn't know how to answer the question because I quite candidly would not have a recollection of something I might have written five

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or ten years ago. I must say nothing comes to mind, but I don't know how to answer the question beyond that.
Q. To the best of your recollection, the answer would be no?
A. To the best of my recollection, it's I don't know. I don't think so, but I don't know.
Q. Same thing with regard to testimony in deposition or at trial. Have there been cases where you have provided testimony as to the cause of a patient's stroke?
A. Hold one second. Could we go off.
Q. Sure.
(Recess.)
MR. MISHKIND: Mr. Kuri is calling Mr. Murphy to see if he is coming.
BY MR. MISHKIND:
Q. Doctor, have you ever testified to your knowledge in a case involving a pulmonary embolism where the issue was whether the pulmonary embolism caused or contributed to a cerebral vascular accident?
A. I don't believe so.
Q. Have you reviewed any cases in the past for Mr. Kuri?

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A. I believe I have had at least one other case with him. Yes.
Q. Is that an open case, to your knowledge, one that you are still involved in?
A. I don't believe so.
Q. What was the medical subject matter of that case?
A. I don't recall. I need the patient's name and the file.
Q. Was your deposition taken in that case, if you recall?
A. I don't recall. I believe I did testify, but I don't recall if my deposition was taken.
Q. You believe you testified at trial in the case?
A. It was either trial or deposition and I'm trying to sort it all out and I don't recall. I know I did give testimony. Beyond that, I don't recall specifically.
Q. When are you scheduled next to testify in deposition after today?
A. In a malpractice case, I have no idea.
Q. In any case?
A. Oh, I think later this week, I think later this week I have a deposition, I believe Wednesday or

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Thursday, I think it's a patient of my own but I know I have one later this week, patient I treated, I believe, but it's not a malpractice case.

Q. Do you know when you are next scheduled to testify in a malpractice case either at deposition or at trial?

A. No, sir. Actually, I do. That's not correct. That is not correct. I have a deposition coming up later in the month because I saw the file on my desk, but it's later in the month.

Q. Any chance that you might remember at this point the subject matter of that case?

A. I remember -- yes. Actually I do because I looked at it not too long ago. It's a patient who had an AVM who hemorrhaged and died.

Q. Are you serving as expert for the plaintiff or defendant in that case?

A. I'm a causation expert for the plaintiff in that case.

Q. Who's the plaintiff's lawyer in that case?

A. It's the Feiger firm in Detroit, and I don't recall the gentleman's name. It begins with a W. I'd have to see the file to give you more than that.

Q. You have done other cases on behalf of

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lawyers for the Reminger & Reminger firm, is that correct?

A. Yes, sir.

Q. Do you remember working for attorney Tom Kilbane?

A. Yes.

Q. Do you know how many cases you reviewed for Mr. Kilbane?

A. I do not.

Q. Do you remember the names of any other attorneys of Reminger & Reminger that you have worked with?

A. If you give me a name I can tell you. I really don't keep a mental list.

Q. You are not able to recollect names, and I'm not faulting you, but let me make it come from a different way.

Do you remember when the last time it was you either testified at deposition or at trial for, at the request of a Reminger & Reminger attorney?

A. It was last year, I'm pretty sure. It was in Cleveland. I don't recall the details, though, but I'm almost positive it was the last half of last year. Yes.

Q. Was that for attorney Mark Groedel?

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A. I have worked with him, but I don't believe that that, I may have the wrong firm, but I don't believe so.

Q. Tell me to the best of your recollection how many cases you have reviewed over the years for the Reminger & Reminger firm?

A. I would guesstimate about a half a dozen over the years, in that ballbark.

Q. And of those half a dozen cases that you have reviewed for them, have you been deposed in all of those cases?

A. No idea.

Q. Are you able to tell me whether you have been deposed in most of those half a dozen cases?

A. My sense would be probably yes but again without a name and a file, I'm sort of guessing a little bit, which I hate to do.

Q. What about other law firms in the Cleveland area. Have you had occasion to work with other lawyers that aren't affiliated with Reminger & Reminger?

A. There is another firm. The answer was yes. That's why I say I don't recall the specifics of when I was there. The answer is yes, but again I'd have to have a name and if it's someone I know

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that I could tell you.

Q. You believe it's just one other firm that you have worked with in Cleveland?

A. I don't know. I don't know. I don't tend to think of it in terms of the makeup of a firm. If I hear a name and it's someone I have worked with, then I'll know who it is.

Q. What about the name of Dirk Reimensneider?

A. Yes.

Q. Does that ring a bell?

A. It sure does.

Q. Have you worked with Mr. Reimensneider as an expert on behalf of clients of his?

A. I have, on a couple of occasions.

Q. The name of the firm is Buckingham Doolittle, does that bring a bell?

A. Yes, it does. Thank you.

Q. You are welcome. I try to help out every once in a while.

A. I appreciate it.

Q. Any other firms or individuals from the defense side that you recall working with other than the two that I just referenced?

A. There is one other, but it escapes me and again I'd have to know the individual's name. I know

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there is another fella I was involved with. I didn't actually testify. I don't think I did. No. I did not. But it was not, I don't think it was from that firm.

Q. Have you ever had your privileges suspended or revoked at any time?

A. No, sir.

Q. Have you ever been the subject of any disciplinary action before any state or local medical association?

A. No, sir.

Q. Have you ever been the party to any medical malpractice cases?

A. Yes, sir.

Q. On how many occasions, sir?

A. Four.

Q. Are any of those cases still active?

A. One.

Q. Are they all in the Washington, D.C. area?

A. Yes.

Q. Have any of those cases, the current one or the previous three, did any of those cases involve any issues surrounding the cause of a stroke in a patient?

A. No, sir. Not even close.

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Q. You never worked at the request of anyone from Becker & Mishkind on any cases, have you?

A. I don't think so. I don't think so. I don't know. I don't think so.

Q. Do you remember testifying as an expert for the defense in a case by the name of Tina Suppa?

A. Sure. I mean, I remember that name. Yes.

Q. And do you remember which law firm you were working for in that case?

A. I don't, but the name I know I have seen before, so the answer is yes to that but I don't recall who the individual was.

Q. Do you know for the calendar year 2003 what your income was from medical legal work?

A. Are you including patients I have operated on and then testified for, my own patients or patients who have not been my own patients?

Q. Patients that have not been your own.

A. I would guesstimate lumping it together probably in that 10 percentish of my total and leaving my own patients out of it.

Q. And has it pretty much been 10 percent over the course of the years?

A. Well, I think it's, well, I'm sure it varies year to year and I'm giving you an estimate.

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Could it be 8 percent or 15 percent or 12 percent, I don't know. But I don't think there has been radical changes over the last few years, no.

Q. Have you received any K-1s or 1099s thus far from any of your medical legal work for the year 2003?

A. I have no idea. They wouldn't come directly to me.

Q. Where would they go to?

A. They would go to the office. They would go to my bookkeeper and I can tell you we don't keep them because my accountant says they don't need to.

Do they come in? I'm assuming they do. I occasionally see these things come in, but beyond that, it's nothing that we really have.

Q. You mentioned something curious. Your accountant says that you don't need to keep them. Do you understand why that is that you don't need to keep them?

A. Yes. I asked him years ago. You get a whole pile of stuff from insurance companies and other places and I asked him is this something we need to save and he says basically knows, I enter it in or when my dad was alive, goes into the corporation. I said fine, so we don't.

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Q. You know, this issue has come up before concerning income that you have received, for example, from Allstate Insurance Company. It's come up in several depositions that you have given where you were paid over $100,000 in 1999 from Allstate Insurance Company. I think you were uncertain as to whether or not that was all for independent work or whether it included payments on patients of your own.

Do you recall that?

A. Yes, sir.

Q. Do you continue to receive income or payments from Allstate Insurance Company for patients both that you see that are not your own, as well as some of your own patients?

A. I can't give a specific answer. My sense is yes. I don't think my practice is vastly different. I see patients for evaluation. It would not really be from Allstate, it would be an attorney and I simply treat patients who they get the bill and they pay me for medical services or surgery, so it's for both.

Q. Who is Harvey Ammerman?

A. He was my father. I practiced with him until he passed away in '93.

Q. Who is James Watts?

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A. Dr. Watts, who has also passed away, was our first chairman at George Washington University, and after he retired, he worked with us in an office setting until he died several years ago.
Q. Your letter to Mr. Kuri is dated August 11th, 2003. It just has your name on it. How long have you been solo in Washington Neurosurgical Associates?
A. Well, I have been actually been solo in reality since March of '93, when my father passed away. When they changed the letterhead, I can't tell you, that is to just leave my name.
Q. Have you had any other doctors that have been affiliated with Washington Neurosurgical Associates other than your dad and Dr. Watts?
A. Not in the last 10 years. We did before that, but not certainly in the last 10 or 15 years.
Q. Do you provide your name through any services that hook lawyers up to doctors for expert review?
A. No, sir. I don't -- I have no affiliations with anybody.
Q. Have you ever advertised your availability to provide expert services?
A. No, sir.

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Q. Tell me how much you charge, Doctor, for review of medical records?
A. $300 per hour.
Q. How much do you charge for deposition testimony?
A. It's $500 for the first hour. If we go into a second hour, I'll charge $300 and to be up front on this, I'm charging an extra hour because it's an extra half-hour to come downtown to do this.
Q. How much do you charge for being out of the city, how much will you be charging when you come to Cleveland, which I presume will involve an entire day away from your practice?
A. $5,000 plus any unusual expenses.
Q. That being hotel, as well as air fare and meals?
A. Exactly.
Q. I was wondering what you meant by unusual expenses.
A. Ones I normally don't have to pay for here in town. Certainly not the hotel portion and the air fare.
Q. The exams that you do on patients that are not your own that are sent to you by other defense attorneys, how many of those do you average a week?

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A. Just defense attorneys?
Q. Yes.
A. I would guesstimate probably two, three a week.
Q. You also do Social Security exams, did you say?
A. Occasionally see Social Security. More commonly than that would be Workmen's Compensation and probably less commonly would be plaintiffs' lawyers who send in to a patient who want a neurological treatment who I don't treat.
Q. What about workers comp exams where you are seeing the patient that it's not your patient, but you are being sent the patient to examine by the Industrial Commission, the employer's side of the table, if you will?
A. Boy, that's a toughy. I see patients for Workmen's Comp sent in sometimes by lawyers, sometimes by the Commission. I'm talking about ones that I don't treat or operate on. Occasionally just for an evaluation from their attorney because they need a status as to how the patient is doing, but I'm going to guess maybe it comes out to once a week kind of thing, in that ballpark, and that's a guess.
Q. Doctor, you have in front of you material

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which I presume relates to the Speicher case?
A. Yes, sir.
Q. Your letter of August 11 of 2003 indicated that you had been forwarded medical records, as well as the reports of Drs. Conomy, Bibler and Bacik.
Was that all of the material that you had as of August 11th that you reviewed to arrive at the opinions expressed in your report?
A. I believe so.
Q. And it looks like you have a black binder in front of you with, are those the medical records?
A. Yes, sir.
Q. Tell me what hospital or hospitals those medical records are from?
A. I have records from Akron General, Barberton Citizens. I also have medical records of Dr. Rich, and medical expenses. That's what's contained in this volume.
Q. Do you have tabs on any of those pages?
A. I got lots of tabs on pages. So I can find records.
Q. Did you place those tabs? I'm sorry.
A. I said so I can find records. I placed all the tabs.
Q. Are there any notes on any of the tabs?

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A. Well, the answer is yes. I wrote cranial CT 2601 so I can find it. I wrote myself a sticky. That kind of thing. But there is nothing in the way of specific notes. I mean I may have written a word or two. I'd have to go back and look. It's mostly tabs or underlining or highlighting specific entries.
Q. Doctor, Mr. Murphy has just arrived. By the way, I failed to ask whether you have ever had the occasion to review cases on behalf of Mr. Murphy or any of his partners at Bonezzi, Switzer and Polito.
A. Thank you. That was the firm. The answer is yes.
Q. Did you have the pleasure of working with Mr. Murphy or someone else from that firm?
A. I believe it was someone else.
Q. Do you remember which lawyer it was in terms of the names that I gave you?
A. I think, give me the names again, please.
Q. Bonezzi, Switzer, Murphy, Polito?
A. Yes.
Q. No? Yes?
A. No, yes, no, yes.
Q. Mr. Switzer?
A. Yes.

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Q. Okay. Do you know how many cases you had occasion to review for the Bonezzi Switzer law firm?
A. I can think of two. There may be a third over the course of a number of years.
Q. Do you know whether any of those cases are active cases, as far as your understanding?
A. I can only think of --
Q. You were still involved as an expert on?
A. Yes. I believe one.
Q. Do you recall the subject matter on that case, by chance?
A. I do not.
Q. Since your report, Doctor, have you received any additional information from Mr. Kuri?
A. The answer is I believe so. I received the films, I believe in October of this year. I'm sorry, '03, the CT. And I received copies of depositions of Drs. Bibler, Bacik and Conomy. And I think that's about it.
Q. Have you seen reports from Dr. Herwig or Dr. Martin?
A. Yes.
Q. Have you seen depositions from Dr. Herwig and Dr. Martin?
A. I don't recall. I was looking before. I

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don't see in my file. I don't recall. I know I got their reports.
Q. Do you have all of your correspondence from Mr. Kuri with you today?
A. I think so. I hope so.
Q. Is there anything that you have removed from the file by way of correspondence or letters or anything relating to this case?
A. No.
Q. Have you received any deposition summaries?
A. I'm sorry. Deposition summaries?
Q. Summaries of any depositions?
A. No.
Q. Yes, sir.
A. I have not.
Q. What about any timelines, timelines or summaries of the medical records?
A. No. Other than what some of the doctors have within their reports or in the depositions.
Q. Have you been provided with any medical literature by Mr. Kuri that you believe to be relevant to this case?
A. No, sir.
Q. Rather than taking the time to have you

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read me all of the letters, just first tell me when it was that you were first consulted and look at Mr. Kuri's letter, if that helps you.
A. July 28, '03. It's very brief. I don't mind reading it to you because it is so brief.
Q. Go ahead.
A. This correspondence, it's very brief. This correspondence will serve to confirm that you have graciously consented to review the above captioned matter on behalf of our client, Dr. Patrick Rich. We request your Frank and candid opinion with regard to the appropriateness of care rendered by our client.
Briefly, by way of background, plaintiff alleges that Dr. Rich failed to properly work up the decedent, M. Jean Speicher and perform the necessary testing to rule out pulmonary embolism which resulted in death and forwarded the medical records that you and I just talked about and then asked me to call, which I guess I did.
Q. Do you have any written notes at all? You told me that you had a sticky for the CT of October, but do you have any handwritten notes or anything else that you have compiled?
A. The only note I was looking when you asked

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me before, I came across, what I did make a note in the October 29, '03 cover letter where they sent me the films, the CT of the head. I have a one-sentence note that says large infarct left MCA distribution acute.

Q. Any other notes?

A. Well, I was flipping through. Other than one that says prior note where I must have asked for the CT, it says will send CT and they did, a week later. If there is a word, I have missed it, but basically no, it's highlighting and underlining and putting a tab on it.

Q. Doctor, in that letter from Mr. Kuri, July 28th letter, he asked you to comment on the appropriateness of the care provided by his client, Dr. Patrick Rich, correct?

A. Yes, sir.

Q. Your report that you wrote on August 11, 2003 does not comment on anything relating to whether Dr. Rich provided acceptable or appropriate care to Mrs. Speicher. Am I reading your report correctly?

A. Correct. After I reviewed all the records, it was clear to me that my role and my expertise was in the neurologic condition she

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suffered which was a left MCA stroke, and its cause and its effect on her longevity, not as an internist or pulmonologist, so I only focused on the areas where I had expertise.

Q. But in fairness, you were asked additionally by Mr. Kuri to comment on the appropriateness of the care provided by his client, correct?

A. Correct. And my feeling was it was out of my area, therefore, that I couldn't do and in conversation as a neurosurgeon since I do have expertise in cerebral vascular disease and its cause, treatment and prognosis, that I did do.

Q. And I take it the same thing would apply in terms of your feeling that you could not comment on the appropriateness of the care provided by Dr. Dean Rich, Dr. Patrick Rich's son, is that correct?

A. Agree.

Q. So you don't have any opinions that you intend to provide at the time of trial as it relates to the issue of whether either or both of the doctors, Dr. Patrick Rich, or Dr. Dean Rich, complied with an accepted standard of care in treating Mrs. Speicher, is that correct?

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A. Yes, sir.

Q. Doctor, I have now been handed by Mr. Kuri a copy of your CV. It has under the publications eight publications, the last being in 1988. Would there be a more current?

A. There is a more current CV then. Because I had one last year.

Q. If you would be so kind as to forward a current CV to Mr. Kuri at sometime in the next week or so, so that we all have an updated one, because the one that we have is four pages with the article on pain management, the symposium from Sibley Memorial Hospital is the last one on your list of publications.

A. I would ask that someone call my office, you can or Mr. Kuri's office. I don't want to take that responsibility and forget or be neglectful. We are pleased to get you one.

MR. KURI: I'll take care of it.

BY MR. MISHKIND:

Q. All right. What I'd also like to do at the end of the deposition rather than taking the time now because I know you have got surgery to do, Mr. Kuri has a deposition, what I'd like to do is to get, mark as exhibits the correspondence that you

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have in front of you, the cover letters and the letter, starting with the letter from July of '03 from Mr. Kuri and the others.

The court reporter perhaps can mark them, attach a copy to the deposition transcript and then return the originals to you. This way you can move on and we can deal with more important things. Is that okay with you?

A. I have absolutely no objection but I have a question. Please help me. The letters are titled Personal and Confidential. Does that mean anything from my standpoint?

Q. It may mean something to you that is personal and confidential but for purposes of the deposition, anything from Reminger & Reminger on this case that you have in front of you, I'm asking that you give to the court reporter and allow her to individually put exhibit stickers on them numbering them consecutively from 1 to 10 or what have you.

MR. KURI: That's fine, Doctor.

THE WITNESS: I have no objection.

BY MR. MISHKIND:

Q. The report that you wrote on August 11, 2003, this contains all of the opinions that I take it you anticipate providing at the trial

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of this case? Is that true?
A. Well, it certainly goes to the causation. The only issue which I touched on tangentially was as a result of this obviously her life expectancy was quite dramatically affected. But those are really the issues. Yes. Not anything much beyond that.
Q. Do you have an opinion as to what her life expectancy would have been had she not suffered the affects of the pulmonary embolism and the stroke and survived the events at the end of January, early part of February of 2001?
A. Yes.
Q. What is that opinion?
A. I think she would have survived some number of years. Now, I think it would have been certainly in the single digit because had she not had the stroke which she did have, we know she has vascular disease there. That's what led to likely thrombosis of her middle artery and that obviously can affect one's life expectancy.
Beyond that, I think single digit would be very good for her, I don't think she would absent the stroke and absent the PE have lived longer than that.
Q. Are you able to be any more specific other than single digits in terms of how much longer she

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would have lived?
A. Well, again, as I say, we know that she has significant amount of vascular disease in her left middle cerebrum. Assuming it had not occluded she was in the hospital, I believe there is a real likelihood it would have in the future. We don't know about other vascular disease in the brain. I don't believe she had an autopsy. A few to seven years, something not beyond that. It would be difficult for me to say.
Q. What would have caused her death in a few to several years?
A. The most likely thing is some type of vascular disease which caused her death during the hospitalization.
Q. What would have been the precipitating event to trigger the symptomatic vascular disease?
A. Well, I think what actually claimed her if I say -- if I assume hypothetically that she did not have her stroke when she was in the hospital, I think there is a real good chance she would have it down the road. And I think the outcome at that point then would have been the same.
Q. Maybe my question wasn't worded well. What would have caused the stroke, it's my

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understanding you feel that she had underlying vascular disease, correct?
A. Yes, sir.
Q. What would have caused her to become symptomatic suffering a stroke that would have taken her life a few to several years down the road?
A. I believe --
Q. What event most likely?
A. I believe the same thing that caused her to die in the hospital. You asked me to assume that didn't happen so I made that assumption, but she clearly had a, I believe arterial sclerotic disease of her left MCA and she had a blockage when she was in the hospital. I think the same scenario would likely have occurred had she not been in the hospital.
Now, if I assume hypothetically it doesn't happen when it did, I think it's going to happen in the future.
Q. Just so I have a framework when I'm asking you questions for the balance of the deposition, if she had not had the pulmonary embolism, can we agree that she most likely would not have been in the hospital in February of 2001?
A. Yes.

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Q. And is there in your mind a relationship between the pulmonary embolism and the development of her stroke?
A. No, sir.
Q. None whatsoever?
A. I don't think one had any direct impact on the other. Correct.
Q. So it's just coincidental that she was in the hospital for the treatment of the pulmonary embolism that she happened to suffer an unrelated stroke. Is that your opinion?
A. Well, I think that's correct. Had she been at home, the same thing would have happened in her bed. She happened to be in the hospital. But based upon the medical records around the time of the stroke before and after, I think that's true.
Q. Now, you said that you have read the testimony of Dr. Herwig and Dr. Martin, or at least the reports?
A. I have their reports. I don't recall whether I actually saw the deps. I just don't recall.
Q. So if Dr. Martin has testified that Jean Speicher's severe hypotension and bradycardia noted around 2 a.m. on February 6th precipitated her

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cerebral vascular accident, would you disagree with that statement?
A. Actually, I think that I would. Yes, sir.
Q. And if Dr. Martin, pulmonary expert for Dr. Dean Rich, has testified that having a massive left middle cerebral artery infarct not have occurred -- I'm sorry.
Let me rephrase that. That the massive left middle cerebral artery infarct would not have occurred in the absence of hemodynamic compromise caused by her recurrent pulmonary thrombo-emboli, I take it you would disagree with that as well?
A. Correct.
Q. Have you seen the opinions of Dr. Bacik, Dr. Conomy and Dr. Bibler, correct?
A. Yes.
Q. And so that I don't have to go through all of their opinions individually, would you agree with me that essentially all of the doctors have opined that the pulmonary embolism caused the patient to become hypotensive and that hypotension then precipitated the stroke that the patient experienced? Is that essentially what all of the experts that you have read have testified to?
A. Those three depositions, I believe would

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agree with that, yes, sir.
Q. Have you seen any testimony either by way of depositions or reports in this case that would support the opinion that you have, and that is, that there was no relationship between the pulmonary embolism and the stroke that the patient suffered during this hospitalization?
A. I can't speak to somebody else's report or testimony. I made my opinion based solely upon the medical records.
Q. Is there any statement by any of the medical caregivers that you see, those people that were caring for the patient during the hospitalization that supports the foundation for your opinion that the stroke was essentially unrelated to the pulmonary embolism?
A. Well, I believe the answer to that would be in the affirmative. And I would refer to, and my records are not Bates stamped, so I can't help you there. But if you were to look at the, pardon me, record timed 12:30 a.m. on the 5th, just so we can be on the same page, and then go to the next page.
Q. Is this a progress note, Doctor?
A. Yes, sir.
Q. Okay.

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A. And then go to the next page. The next page isn't dated but we know it has to be subsequent to the 12:30 a.m. or a portion thereof actually, a portion thereof.
I'll wait until you find that. At the top it says PICU-4. It's a progress note and the bottom left in the, where it says date, time, it just says note.
Q. This is in the PICU?
A. Yes. These are handwritten notes, Akron General Medical Center. And it's part of the note that's written at 12:30 a.m. Let me know when you find that note.
Q. What does the 12:30 a.m. note start with?
A. Patient getting TPA. Progressively worsening. Okay. Go to the next page. At the top of the page, it talks about the patient being intubated. Talks about the blood pressure. Are we there?
Q. Yes, I am, sir.
A. Blood pressure of 128 over 70 and then the note at the bottom that says, patient had been awake, alert, talking with pulse and blood pressure throughout prior to intubation. Never lost blood pressure, pulse despite everything. If the patient

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is able to talk, communicate, be awake and alert, even though the patient is somewhat hypotensive, which she was for a while, she clearly would not precipitate the stroke or she would not be awake, alert and talking. So that event has to occur after the patient was intubated.
After the patient was intubated, her blood pressure was 120 over 70 and yet she was soon found to have dilated pupils with a low but adequate blood pressure, and after all the drugs wore off, it became clear that something more had gone on. She had her CT that showed this massive stroke which obviously occurred subsequent to her intubation after her blood pressure was actually pretty good.
Q. What was her blood pressure after intubation?
A. Depending upon which time her blood pressure was, correction, 120 over 70, at 1 o'clock, correction, at 2340, which was before it was 80 over 50 then she has her intubation, 120 over 70, 85 to 90 over 60, and by then she's had her stroke and in the early morning hours after the event, that is after intubation, after her stroke, she has one blood pressure 75 over 38 then I believe it's 88 over 47, 101/58, and 111/62.

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Q. Do you have any evidence that you can point me to that substantiates that this patient had, prior to the stroke, that she had significant cerebral artery thrombosis?
A. I'm not sure I understood what you are asking me.
Q. Where was the occlusion in the distribution of the left middle cerebral artery, where exactly?
A. Based upon the CT scan, it would be at the proximal beginning of the left MCA.
Q. And how long had she had this occlusion?
A. Well, she had the complete occlusion sometime after she's intubated because she is awake and alert and talking before which she couldn't do if she had a complete occlusion. She obviously had disease at that site which occluded sometime after intubation, sometime after her blood pressure was probably actually better.
Q. What degree of occlusion do you believe she had prior to the admission to the hospital?
A. I suspect it was probably, and this is absolutely speculative because we don't have an answer. It had to be a significant degree, one which was not symptomatic, hemodynamically, which means it

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was probably less than 70 or 80 percent. Beyond that, there is no way of me knowing without studies and there would be no specific reason to do those studies.
Q. Her doppler ultrasound in January of 2000 was normal, correct?
A. Her doppler of her carotids I believe was, yes, sir.
Q. And is that of any significance in terms of giving you an indication as to the extent of the disease process that she had in the distribution of the left middle cerebral artery prior to February of 2001?
A. It's not going to because you can have disease in the carotids and the middle cerebral may look pretty good, may look fine and vice versa, so the answer is no. It's not going to help us one way or the other. You'd have to do either CTA or MRA or an angiogram to assess that issue.
Q. And she had in your opinion prior to the admission to the hospital less than 70 percent occlusion of the proximal distribution of the left middle cerebral artery?
A. What I said it was speculative in my guess, and it is a guess because she never had the

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studies. I said it was probably in the range of 70 to 80, not knowing her collateral. It could have been more. I have no way of knowing. That I don't have a study which would tell me what for example her collateral flow was and whether she had higher degree stenosis, a lower degree. I can't tell you.
Q. What event occurred then to cause the, in your opinion, to cause the total occlusion and thus the stroke?
A. I think the most likely is that she had a thrombosis, that is, she had an arteriosclerotic disease. She is entitled certainly by age, 77, and occlusions occur all the time. Patients sleeping, patients sitting at their breakfast table. Whether a small plaque came off, which is the other type of stroke, thrombotic that occurs, I have no way of knowing. I don't believe she had an autopsy. As I mentioned, I don't believe we have any type of good vascular study done before. That is the most common.
Obviously an embolism is always a consideration. Middle cerebrum is always a thought. It's certainly a possible -- I think a localized thrombosis on a arteriosclerotic basis is most likely and often the acute ones because of the plaque on there suddenly gets a thrombosis on it and there is

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an occlusion.
Q. Do you have any scientific evidence from the hospital record that you could point to that would support a local thrombotic event that caused the occlusion in the cerebrum?
A. Local -- well, let me work backwards. I don't think there is any debate she had a massive left cerebral infarct from the distribution from the MCA. It has to occlude by thrombosis or from an embolism. Both are certainly possible. The more likely and the more typical is going to be a thrombosis.
We know that she had adequate perfusion to her left MCA distribution up until the time she is intubated. The note makes it very clear. That's in spite of her lower blood pressure after she is intubated. Then she has a stroke. I think she had a run of the mill thrombosis in someone who has an MCA which is not an unusual cause of death of someone in their late 70s.
Q. In terms of an embolic event taking place, by definition, are you satisfied that she most likely did not have an embolic event causing the CVA?
A. I think it would be less likely than a thrombotic because the entire vessel was occluded.

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That is the entire distribution of the middle cerebrum was occluded.
Q. What injury did the patient in your opinion, Jean Speicher, suffer as a direct result of the pulmonary embolism and the treatment that was provided for the pulmonary embolism?
A. What condition?
Q. What injuries, what effect on her body?
A. She clearly had stress on her cardiovascular pulmonary system which actually looks to have been gotten straightened out prior to the time, just prior to the time she had her stroke. She obviously had some degree of hemodynamic effect. That's why she was hypotensive, required various medication she did, and indeed the intubation.
Q. Do you have an opinion as to what her degree of disability or morbidity would have been had she not suffered the stroke, but had recovered following the treatment for her PE?
MR. KURI: Objection. Go ahead.
THE WITNESS: You are getting me a little bit out of my area of expertise. I'm not a pulmonologist. I have had patients survive PEs obviously. Depending on the severity, they may or may not have had pulmonary limitations. Otherwise

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they tend to do reasonably well for those who survive.
BY MR. MISHKIND:
Q. But you would defer to a pulmonary expert with regard to the specifics of any morbidity or mortality that would be associated with the pulmonary embolism in this case, is that correct?
A. Well, not completely. If somebody says that this woman died because of a pulmonary embolism, I would take issue with that. If somebody who was a pulmonologist were to discuss the long-term limitations or lack thereof of someone who has had a PE and gotten over it, I would certainly defer to them.
Q. The death certificate, have you seen that in this case?
A. I believe so. Yes.
Q. If could you pull that out for a moment.
A. Sure. Yes, sir. I have it here.
Q. We know there is no autopsy, but we know the death certificate is signed by a physician.
A. Yes. I can't catch what you first said.
Q. We know there was no autopsy.
A. Yes. Thank you.
Q. Do you recognize the name of the physician

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in terms of whether or not he was involved in any aspect of the care of Mrs. Speicher in the hospital?
A. I'm not sure I can read the signature, so I can't answer the question. Yes, I can. Ginella. I haven't focused on it one way or the other. I don't know.
Q. And what is Dr. Ginella's opinion as to the cause of death?
A. Respiratory failure secondary to pulmonary embolism.
Q. And I take it then Dr. Ginella would be included on the list of doctors that you disagree with in terms of cause of death in this case?
A. I would agree because I think it's incomplete.
Q. You disagree with his opinion as to the cause of death, correct?
A. Correct. I think it's incomplete.
Q. Well, was the pulmonary, was the respiratory failure secondary to the pulmonary embolism a contributing factor to the patient's death?
A. Actually it probably was not based upon the records that we talked about.
Q. So then you disagree entirely with what

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Dr. Ginella says in the death certificate, both incomplete as well as that which is stated? Correct?
A. I think as it's stated there is inaccurate. Correct. The patient died of a massive brain herniation from her stroke.
Q. Totally unrelated to the pulmonary embolism in your professional opinion?
A. It is because she had been stabilized. Her neurologic status was absolutely fine during her rockiest time of treatment for her hypotension from her PE, and that was actually stabilized, and then she had her stroke, so I believe it is clearly, it clearly is independent.
Q. I think you touched on before that a stroke can be caused by hypotension, correct?
A. Sure. You can get cerebral anoxia.
Q. If a patient has pre-existing ischemic disease of an artery, are they at greater risk of a stroke during severe hypotensive episodes?
A. They can be.
Q. And if a patient has a severe hypotensive episode and has pre-existing ischemic disease, what is the most common mechanism that causes the stroke from a pathophysiological standpoint during that hypotensive episode?

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A. It would be diminished flow due to some degree of obstruction.
Q. Would diminished lull due to the obstruction cause the same results as a thrombosis in an otherwise ischemic artery?
A. It can. The answer is yes. It can.
Q. Are there any studies that were done immediately after the stroke or prior to Mrs. Speicher's death that would confirm that there was some thrombotic event, some plaque, if you will, that occluded the pre-existing ischemic artery leading to this patient's stroke?
A. I don't believe she ever had an MRA or a CTA. And I don't believe she had an autopsy. The only thing I saw was a CT scan that was done after the fact so beyond that, I did not see anything.
Q. And the CT doesn't indicate that there was a thrombotic event superimposed on pre-existing ischemic artery causing the stroke, correct?
A. Correct. All the CT will show is the effect of blockage of the left main middle cerebral artery.
Q. And what is shown on the CT can just as easily be indicative from a pathophysiological standpoint of a profusion defect caused by

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hypotension in a patient that has underlying ischemia of the artery, correct?
A. It can be. That's why you can't tell clinically from looking at the scan and must correlate it as I did with the medical records which demonstrate that that distribution, the left MCA which not only would go towards alertness and awakeness but also speech was normal right up until the time she was intubated and her blood pressure was actually better, so you can't tell looking at the scan the pathophysiology. You can just tell there has been a big infarct.
Q. You read over Dr. Conomy's deposition?
A. I did. Yes, sir.
Q. Do you know Dr. Conomy, by the way?
A. No, sir.
Q. Never met him?
A. No, sir.
Q. I'm going to ask you whether you agree or disagree with certain statements that Dr. Conomy has made and if you disagree, tell me why and hopefully we'll be able to wrap things up?
A. Okay. Otherwise I need to take a short break.
Q. What time do you need to be somewhere,

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Doctor?
A. We are fine. My surgery isn't until about 4 o'clock, and I think it's only 20 after two.
Q. Do you agree with Dr. Conomy when he indicates that Mrs. Speicher's stenotic cerebral vascular disease became symptomatic only under circumstances of severe and sustained systemic hypotension and there is no reason to think that that would have happened until it became severe?
A. I disagree with that statement.
Q. And without repeating that which we have already said, would you tell me why you disagree with it?
A. Well, it would be hard to without repeating some of what I have said because she did have hypotension, which was dealt with and was improved. During her period of hypotension, she never had a stroke. She was awake and talking, and so that statement is not accurate.
Q. Any other basis for your statement other than what you just said?
A. Well I'm just relying on the contemporaneous medical records that says she is awake, alert, and talking.
Q. Have you reviewed the mean arterial

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pressures and the graphics on patient's blood pressure?
A. On this patient?
Q. Yes.
A. I have looked at the chart. I don't specifically recall which ones I have looked at.
Q. Would a sustained mean arterial pressure between 60 and 80 be considered for a period of over an hour, would that be considered sustained hypotension?
A. A mean of 60 to 80 is mild hypotension. You are talking about the mean. Yes. That is mild hypotension. Yes, sir. It is.
Q. And is mild hypotension in a patient that has underlying ischemic disease, is that sufficient enough in an ill patient, that is a patient that's in the hospital being treated for pulmonary embolism, is that enough to cause systemic hypotension leading to a stroke due to inadequate profusion?
A. It would be usual if somebody has a mean for example 70 or 80 to have any problem with it. That's not hypotensive unless the patient had a history of severe hypertension. But the real issue is not whether it's 60, 70 or 80. It's whether at those levels it affected the cerebrovascular. If the

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patient is awake and talking, whether it's 50, 60, 80 or 50, it ain't doing it.
Q. Do you know how long a period of time the patient was awake and talking continuously prior to the stroke from a note that you read or from anything else in the record?
A. Well, let me just refer to the note because that is what I am relying on which says awake, alert and talking throughout, throughout prior to intubation. And then after she's intubated, she was unresponsive, of course, she had a lot of drugs. She also had a stroke and her blood pressure is being maintained immediately afterwards at a level that clearly would not cause that.
Q. Doctor, would you agree with Dr. Conomy's statement that a PE, pulmonary embolism precipitating hypotension in an ill hospitalized patient is not an uncommon situation?
A. PE causing hypotension? That's not rare. I agree with that.
Q. Of what significance is the normal carotid ultrasound in January of 2000, just in terms of the magnitude of the underlying disease process between January of 2000 and February of 2001?
A. Really not much.

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MR. KURI: Objection. Asked and answered.
THE WITNESS: I think we went over that earlier. That is, you can have fairly significant carotid disease and the intracranial vessels look good or not good or vice versa. So you need something more specific than that. It's not any good for the middle cerebral.
BY MR. MISHKIND:
Q. You do agree that she had stenotic cerebral vascular disease, correct?
A. Yes, sir.
Q. Where it appears that you and Dr. Conomy disagree, and let me know, is that you believe that she had underlying stenosis of an important artery that prior to her admission to the hospital was a symptomatic, first let me stop at that point. You agree with that statement, correct?
A. Yes.
Q. And prior to her admission, this stenosis or narrowing was caused by a disease process that had not been impacting the patient's quality of life as far as you could tell, correct?
A. Yes.
Q. The difference in your opinion and Dr. Conomy's is you believe that after a period of

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time the plaque or the atherosclerotic disease in the artery on the wall of the, the lumen if you will, broke off causing a complete occlusion of the distribution to the left middle cerebral artery that just coincidentally happened at a time that this patient was being treated for the impact of a PE?
A. Well, except I don't know that it broke off. We know it thrombosed. Whether it developed clot just like a coronary occurs. It can break off or you can get clot locally in an acute thrombosis. We have no way of knowing which it was. But with that caveat, that's correct.
Q. And other than your read of the record in terms of her consciousness and your interpretation of her blood pressure, there is no scientific evidence in the record that you can point to to support the occurrence of a thrombotic event leading to the CVA, true?
A. It's either thrombotic or embolic. There are only two options so absolutely unequivocal it's more than the other. I think thrombosis seems to be more common. There was not an autopsy. We'll never know. She is awake, alert and talking during that period of time. She has not had a vascular event. Her blood pressure is better after than before, and

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she does have a vascular event.
Q. Well, inadequate profusion would be a vascular event, correct?
A. No, sir. Not unless it's symptomatic.
Q. If the patient's hypotension was the cause of the stroke, would that be considered a thrombotic, would that precipitate a thrombotic event?
A. Could it, if the patient dropped their blood pressure, no, if she had a stroke at that point. They are working her up, treating her and she has a stroke when her blood pressure bottoms out, the answer is yes.
Q. That can cause a localized thrombosis?
A. The answer is it absolutely could, and with that, almost instantly the patient would lose her ability to sleep -- to speak and she would become obtunded. She would lose her speech like that. Apparently she never did.
Q. You would expect if there was a hypotensive episode leading to the CVA that from a graphic standpoint, you would expect the graphic blood pressure to drop down almost instantaneously?
A. Not necessarily at all. No, sir. I would not. If the hypotension led to the stroke which it can, the patient during that period of time would

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have their stroke and manifest the symptoms of it, including in this case an immediate inability to speak, and the records would contradict that as having occurred. Off the record.

(Discussion off the record.)

BY MR. MISHKIND:

Q. The experts that have been deposed in this case from both sides have opined at Mrs. Speicher's stroke was caused by systemic hypotension, coupled with resultant cerebral blood flow defect. I believe regional. Let me strike that and start over again.

The experts of the deposed that have opined in this case have indicated that the stroke was caused by systemic hypotension coupled with resultant regional cerebral blood flow defect caused by pre-existing stenosis of the middle left artery.

I take it that as stated you disagree with that opinion?

A. Yes.

Q. For the reasons that we have said before. You don't believe that she had the hypotension had resolved in your opinion and it was therefore not causative of the cerebral blood flow defect leading to the stroke?

A. Right. Her blood pressure had stabilized

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clearly as we have talked about, and if it was related to the hypotension, it would have occurred during that period of time. The note that we have discussed clearly makes it clear that that could not have happened or did not happen.

Q. How long before you believe she had stabilized, had she had a hypotensive episodes prior to her stroke?

A. Well, she was hypotensive and being treated and indeed that was one of the reasons for stabilization. She was intubated, her blood pressure up to that point and we went through the numbers earlier and indeed after she was intubated, her blood pressure is even better.

Q. How long after her intubation did she suffer the stroke?

A. The intubation I believe was around 12:30ish, and her stroke appears to have occurred sometime after that, and probably before 2 a.m. or in that general ballpark.

Q. And it's your opinion that the hypotension that had occurred prior to the stroke that you believe had resolved would not be enough of a causative event to precipitate a profusion defect sufficient to cause a stroke?

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A. Based upon the numbers and the fact --

Q. Correct?

A. Yes. Based upon the numbers and the fact that she was awake, alert and speaking during all of those blood pressures we talked about earlier, she is her own test case, correct. I don't believe it would.

Q. What impact in your opinion did the hypotensive episode prior to intubation have on the development of the thrombosis?

A. Probably none.

Q. You said you reviewed Dr. Conomy's deposition. When did you review it last?

A. I looked at it within the last few days and then I looked at it a while ago.

Q. Did you look at his, the exhibits that he drew of the distribution of the left cerebral artery, as well as the discussion of the brain flow auto regulation, Exhibit D from his deposition?

A. Sure.

Q. And Exhibit C was the diagram of the occlusion in the left middle cerebral artery?

A. I believe so. The one says to Phil at the top.

Q. Right.

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A. Yes, sir.

Q. In terms of his explanation, the algorithm or the auto regulation graph that he has prepared, do you take issue with his explanation given his deposition and the chart that he has drawn?

A. Well, I can't rely upon the chart specifically. The concept of auto regulation, he is absolutely correct. However, any individual patient is their own best test model, and indeed in some patients, the blood pressure of 90 can cause problems.

In another patient, you'll tolerate 50. If the patient had complete loss of auto regulation, she would have infarct her whole brain which she know she didn't do, i.e., blood pressure had gotten that low and she had no cerebral profusion.

If the levels that she had gotten to at her lowest did not support adequate flow through her left MCA which could have happened, she would not have been awake, alert and talking and she was. So what he writes is in theory applicable in the general sense. I absolutely agree, but in this case, I don't think it fits.

Q. So his theory of inadequate profusion caused by the systemic hypotension is in your opinion

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based in this case incorrect?
A. Based upon the notes that we have, we have talked about a number of times, I agree with you. It is incorrect.
Q. And all of the other experts who have reviewed this case and provided opinions on the cause of the stroke are also incorrect?
A. Can't speak for everyone else but if you read the note and rely upon the note and its contemporaneous timing to the events, this theory doesn't fit. Without that note and if one had skipped over reading that note, you might come to a different conclusion, but it's there in the flow sheet of the chart.
Q. Doctor, beside the opinion as it relates to the cause of the stroke, as well as your opinion that you expressed in terms of her life expectancy had she not suffered the stroke at that time, do you have any other opinions that you have arrived at and that you intend to provide at the trial of this matter?
A. I think those are the two areas.
Q. And have we covered the bases upon which you have arrived at those opinions during the course of this deposition?

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A. Yes.
Q. And you talked about life expectancy?
A. Yes. You just mentioned that a minute ago.
Q. We touched on that?
A. Yes.
Q. Exactly. Doctor, I don't believe I have any further questions for you. Obviously to the extent that you arrive at any additional opinions or change your opinions between now and the time of the trial, I'd ask that you notify Mr. Kuri, otherwise, I have no further questions for you.
A. Thank you. That's fair.
MR. MURPHY: I have no questions. Patrick Murphy speaking.
MR. KURI: Doctor, I assume you are going to want to read this?
THE WITNESS: Yes, sir.
MR. KURI: All right.
MR. MISHKIND: Normal delivery is fine. However you want to arrange for the signature through Mr. Kuri. You have my email and I'll take a regular as well as email transcript, Miss Court Reporter.
(Ammerman Exhibit Nos. 1-4 were marked for identification.)

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(Whereupon, at 2:45 p.m., the taking of the instant deposition ceased.)

_____
Signature of the Witness

SUBSCRIBED AND SWORN to before me this _____ day of _____, 2004

_____
NOTARY PUBLIC
My Commission expires: _____

T